



**Application to Start or Stop  
Payment of Retirement  
Benefits to a Revocable Trust**  
State Form 50928 (07-01-2008)

**PRIVACY NOTICE**

Your Social Security Number is requested by this agency in accordance with the requirements of the Internal Revenue Code. Disclosure is mandatory and this form will not be processed without this information.

Indiana Code 5-10.2-4-7(e) allows a member to direct their monthly benefit payment to a Revocable Trust. In order to qualify, the trust must permit unrestricted/unconditional access to amounts held in the trust and must be revocable at any time. Members may make this election at the time they retire or at any time thereafter.

**To Start Payments**

If you wish to begin directing your benefit payments to an *eligible* Revocable Trust, you should complete the Member Information section on this page and Part A of this form. Part B may be discarded. You will need to indicate if you wish a monthly check mailed to you for deposit or wish payment to be made by EFT (Direct Deposit). If you elect EFT payment, then an *Authorization for Deposit of Recurring Payment* (State Form 39175) must be submitted with this application. If you wish payment by check, the check will be mailed to you and the payee will be: "*Your Name, Revocable Trust*".

**IMPORTANT:** You should consult with your tax advisor before completing this form. You may need to obtain a Taxpayer Identification Number other than your Social Security Number for the revocable trust.

**To Stop Payments**

If you wish to stop further payments to a Revocable Trust you should complete the Member Information section on this page and Part B of this form. Part A can be discarded.

Please return the form to the following address:

**Public Employees' Retirement Fund  
143 West Market Street  
Indianapolis, IN 46204**

**MEMBER INFORMATION**

Member Name (Last, First, Middle Initial)		Social Security Number	
Address			
City		State	ZIP Code
E-mail Address		Home Phone Number	Other Phone Number

Member Name (Last, First, Middle Initial)

Social Security Number

**Part A: REVOCABLE TRUST AUTHORIZATION and AFFIDAVIT**

**Complete this section only if you wish your monthly benefit paid to a Revocable Trust**

**Payment Method (select only 1)**

☐

**Sent to me by Check**

☐

**Electronic Funds Transfer** (Complete a Direct Deposit Form)

I hereby certify that I have requested the Indiana Public Employees' Retirement Fund pay my monthly retirement benefit to my Revocable Trust identified as:

\_\_\_\_\_  
(Print Name of Trust)

\_\_\_\_\_  
(Social Security Number or Taxpayer ID Number)

I further certify that the before stated trust complies with terms set forth in Indiana Code section 5-10.2-4-7(e). I can revoke the trust at any time and I have unconditional access to trust funds.

I acknowledge and agree that the payee designation will be in *my name* Revocable Trust.

I further acknowledge and agree that, should there be a change in the terms or conditions of the trust instrument that would conflict with the provisions of IC 5-10.2-4-7(e), I will immediately notify the Fund and cooperate with the Fund to ensure that retirement benefit distributions are made in compliance with law.

I also hereby agree and acknowledge that the terms of this instrument shall be binding upon my heirs, executors, administrators and assigns and I will hold the Fund harmless for any and all damages suffered as a result of any misrepresentation made in this instrument or by any of act or omission with regard to the terms or administration of the trust.

I also hereby acknowledge that I understand the terms of this affidavit and any ambiguities herein are to be resolved in favor of the Indiana Public Employees' Retirement Fund. I hereby acknowledge that I have had ample time and opportunity to secure legal counsel for the purpose of explaining any of these declarations contained within. I affirm, under the penalties for perjury, that the foregoing representations are true.

State of \_\_\_\_\_

\_\_\_\_\_  
Member signature

§

County of \_\_\_\_\_

Subscribed and sworn to before me, a Notary Public in and for the State and County above named,

by the said \_\_\_\_\_  
Member (please print)

on this date \_\_\_\_\_  
month day year

\_\_\_\_\_  
County of Residence

\_\_\_\_\_  
Notary signature and Seal

\_\_\_\_\_  
Commission Expiration Date

\_\_\_\_\_  
Notary's name (please print)

Member Name (Last, First, Middle Initial)

Social Security Number

**Part B: REVOCABLE TRUST STOP PAYMENT AFFIDAVIT**

**Complete this section only if you wish to stop payment to a Revocable Trust**

Effective with the receipt to this notice I hereby authorize and direct the Public Employees' Retirement Fund to stop payment of my monthly benefit to my Revocable Trust. I understand that it is my responsibility to submit this form in a timely fashion and that failure to do will absolve the Fund from any responsibility for payments that may be misdirected.

I understand that my monthly benefit payments will be made by check payable to me unless I complete a new *Authorization for Deposit of Recurring Payment* (State Form 39175) and submit same with this application.

State of \_\_\_\_\_ Member signature \_\_\_\_\_

County of \_\_\_\_\_ §

Subscribed and sworn to before me, a Notary Public in and for the State and County above named,

by the said \_\_\_\_\_  
Member (please print)

on this date \_\_\_\_\_  
month day year

\_\_\_\_\_  
County of Residence

\_\_\_\_\_  
Notary signature and Seal

\_\_\_\_\_  
Commission Expiration Date

\_\_\_\_\_  
Notary's name (please print)